

***United States Court of Appeals
for the Second Circuit***



**BRIEF FOR
APPELLANT**

77-7102, 7114

United States Court of Appeals FOR THE SECOND CIRCUIT

Docket Nos. 77-7102 and 77-7114

NEW YORK ASSOCIATION OF HOMES
FOR AGING, et al.,

Plaintiffs-Appellants,

against

PHILIP L. TOIA, as Commissioner of Social Services
of the State of New York, et al.,

Defendants-Appellees.

JOSEPH BULLA, et al.,

Plaintiffs-Appellants,

against

PHILIP L. TOIA, as Commissioner of Social Services
of the State of New York, et al.,

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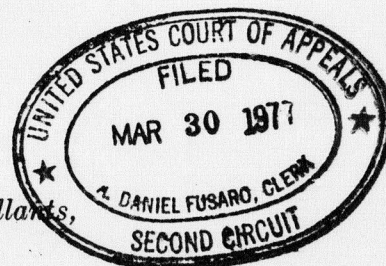
APPEALS FROM ORDERS OF THE UNITED STATES DISTRICT
COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

BRIEF FOR PLAINTIFFS-APPELLANTS IN DOCKET NO. 77-7102

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OTHER AUTHORITIES:

- Conference Committee Report No. 92-1605, U.S. Code Cong. & Admin.
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ISSUES PRESENTED

1. Whether New York State's methodology for computing Medicaid reimbursement rates for services rendered by residential health care facilities (10 NYCRR Part 86-2) and the rates calculated thereunder, which were intended to and did in fact limit total Medicaid reimbursement expenditures by the State to a predetermined budgeted amount, violate federal Medicaid standards because they do not provide for reimbursement on a reasonable cost related basis.

2. Whether regulations setting forth New York State's Medicaid reimbursement methodology (10 NYCRR Part 86-2) and the rates calculated thereunder, which as of November 1, 1976 effected reductions in the level of Medicaid assistance with respect to patients in over 60% of the nonprofit residential health care facilities in the plaintiff class, are invalid for any one of the following reasons:

(a) The regulations were promulgated:

(i) without the opportunity for consultation with the Medical Care Advisory Committee, as required by the Medicaid Act and federal regulations;

(ii) in defiance of State notice, comment and procedural rules asserted by the State to be inapplicable because of a fiscal crisis.

(b) The reductions in assistance effected by the rates were accomplished:

(i) without prior notice and hearings to Medicaid recipients, in violation of the United States Constitution and federal regulations.

(ii) without the 60 day notice which State law requires to be given to all providers of residential health care services prior to implementation of new reimbursement rates.

3. In light of the evidence demonstrating that plaintiffs were likely to succeed on the merits of their action, or at least had raised sufficiently serious questions going to the merits so as to make them fair grounds for litigation, did the Court below abuse its discretion by failing to issue a preliminary injunction to prevent the undisputed irreparable injury which the challenged regulations and rates were causing to residential health care facilities and their patients.

STATEMENT OF THE CASE

This is an appeal (JA 516)* from an order announced from the bench on February 9, 1977 by the United States District Court for the Southern District of New York (Thomas P. Griesa, J.) denying the motion of plaintiffs-appellants (hereinafter "plaintiffs") for a preliminary injunction enjoining defendants-appellees (hereinafter "defendants"), pending adjudication on the merits, from applying Part 86-2 of Title 10 of the New York Code of Rules and Regulations (hereinafter "NYCRR") or the

* The Joint Appendix is referred to herein as "JA".

Medicaid reimbursements rates promulgated thereunder, to the plaintiff class of nonprofit residential health care facilities, insofar as such Medicaid reimbursement rates effect reductions in the rates at which said facilities were being reimbursed as of October 31, 1976.

The action was instituted on November 16, 1976.* Hearings on plaintiffs' application for a preliminary injunction began on December 2, 1976, were continued at Judge Griesa's direction on eight separate dates, and culminated on February 9, 1977 in a decision denying the application.** Plaintiffs' motion for an injunction pending appeal was denied by the district court on February 28 and by this Court from the bench on March 15. However, in recognition of what Judge Feinberg, at oral argument, described as the "grave" issues involved, the denial was without prejudice to plaintiffs' right to renew the motion upon argument of this appeal, and an expedited schedule for briefing and argument was directed.

This class action*** is brought on behalf of 386 nonprofit

* The bases for federal jurisdiction are set forth in paragraph 4 of the complaint. (JA 3)

** Plaintiffs submitted a formal written order embodying the decision announced orally, but were advised by Judge Griesa's law clerk on February 22 that the Judge considered a written order unnecessary and regarded the transcript of February 9 (JA 2020-2022) as an adequate basis for appeal. There are no formal findings of fact and conclusions of law and no written opinion.

*** While no formal class action order has been entered, the court below treated this as a proper class action, recognizing that "...this has been brought as a class action and one -- although there are some formalities about class action we haven't gone through, one must assume that there is some reliance on this action by the associations and their members." (JA 1579-1580)

residential health care facilities in the State of New York which provide services to Medicaid-sponsored patients. The named plaintiffs are two associations of nonprofit residential health care facilities and five nonprofit facilities. The complaint (JA 1-44)* seeks to declare illegal and enjoin Part 86-2 of 10 NYCRR and the Medicaid reimbursement rates calculated thereunder on the grounds, among others, that the challenged regulations and rates:

1) violate the requirement of federal law that reimbursement must be based on the reasonable cost of rendering services to Medicaid-sponsored patients; and

2) were adopted in violation of procedures mandated by the United States Constitution and applicable federal regulations, (including the requirements of prior notice and hearing, and consultation with the State Medical Care Advisory Committee) as well as in violation of applicable state statutes.

The challenged Medicaid rates, announced on or about November 1, 1976, substantially reduced the existing reimbursement rates of more than 60 percent of the plaintiff class. (JA 76) As more fully set forth below, plaintiffs sought a preliminary injunction to avert the threat of immediate and irreparable injury, posed by the new rates, to the ability of these nonprofit facilities to

* In paragraph 2 of his affidavit in support of the preliminary injunction, Mitchell Waife, Executive Vice President of plaintiff New York Association of Homes for Aging, verified the allegations of the complaint (JA 74). There will therefore be references herein to the complaint to support assertions of fact.

STATEMENT OF FACTS

The Medicaid Program

In 1966, Congress adopted the federal-state co-operative public assistance program under Title XIX of the Social Security Act (42 U.S.C. §1396 et seq.) known as "Medicaid". Medicaid was enacted for the purpose of enabling states to make available medical assistance for individuals with economic resources insufficient to meet the costs of necessary medical services. Among the services for which federal funds are supplied are the services provided by residential health care facilities (i.e., skilled nursing and intermediate care facilities*).

To participate in the Medicaid program, and thereby obtain federal funds, a state must submit to the Secretary of HEW a plan for medical assistance ("State Plan") which comports with the requirements of 42 U.S.C. §1396a. New York's State Plan was submitted to and approved by HEW in 1966. It provided, among other things, for payment to residential health care facilities for services to Medicaid-sponsored patients. (JA 11)

The particular reimbursement rates to be paid to residential health care facilities are established by the individual states. Prior to July 1, 1976, the only federal statutory provision governing reimbursement was 42 U.S.C. §1396a(a)(30), which requires that State Plans ensure that reimbursement rates for

* To be eligible to receive Medicaid reimbursement for services to Medicaid-sponsored patients, skilled nursing and intermediate care facilities must comply with federal certification standards and provide a specified range of services. See 45 C.F.R. §§249.10(b)(4)(i); 249.10(b)(15); 249.12 and 20 C.F.R. §§405.127-128a.

medical services "are not in excess of reasonable charges consistent with efficiency, economy and quality of care." In implementing 42 U.S.C. §1396a(a)(30), the Secretary of HEW promulgated regulations (45 C.F.R. §250.30(b)), which established as the upper limit on state Medicaid reimbursement payments the amount of reimbursement payments made under Medicare (Title XVIII of the Social Security Act).

In 1972, the Social Security Act was amended (Pub. L. 92-603, §249(a)) to require that State Plans provide:

"Effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary...."
(42 U.S.C. §1396a(a)(13)(E))

Before adoption of this "cost-related" reimbursement requirement, State Plans were permitted, in cases where the state-established rate failed to reimburse for reasonable costs, to include a "supplementation program," under which providers could solicit additional payments from a patient's friends or relatives who were not otherwise legally obligated to contribute to the patient's support, or from the patient's own otherwise exempt income and resources. (45 C.F.R. §250.30(a)(7)) Concurrent with the July 1, 1976 effective date of 42 U.S.C. §1396a(a)(13)(E), however, the regulations permitting supplementation programs were deleted and providers of services to Medicaid-sponsored patients are now required to accept Medicaid reimbursement as payment in full. (45 C.F.R. 250.30(a)(8))

Medicaid Reimbursement for Residential Health-Care Facilities
in New York

(1) Public Health Law §2807(3) and Part 86 of 10 NYCRR

From the start of its participation in the Medicaid program, New York used a cost related reimbursement system. Public Health Law §2807(3), enacted in 1965, required the Commissioner of Health, who promulgated Medicaid reimbursement rates, to certify each year that such rates were "reasonably related to the costs of providing" health care services.

In 1969, §2807(3) was amended to provide that reimbursement rates be "reasonably related to the costs of efficient production" of health care services. (Emphasis added) To arrive at rates which would in fact be "reasonably related to the costs of efficient production", the Commissioner of Health was directed, pursuant to amended §2807(3), to:

"take into consideration the elements of cost, geographic differentials in the elements of cost considered, economic factors in the area in which [the facility] is located, the rate of increase or decrease of the economy in the area in which [the facility] is located, costs of [facilities] of comparable size, and the need for incentives to improve service and institute economies."

To implement amended §2807(3), on July 1, 1970 the Commissioner of Health promulgated regulations (Part 86 of 10 NYCRR)* which set forth the methodology for rate calculation. In brief, rates were calculated under Part 86 as follows: (1) All facilities in the State were "grouped" according to bed size, geographic lo-

* Part 86 is Document No. 3 in the separate pamphlet, submitted herewith pursuant to Rule 28(f) of FRAP, entitled "Statutes, Regulations and Unreported Decisions Relevant to the Appeal" ("Plaintiffs' Addendum").

cation and type of ownership (nonprofit vs. proprietary). (§86.13)

(2) The actual costs each facility had incurred in a "base" year* were determined on the basis of required annual certified financial reports. (§§86.3, 86.6, 86.7) (3) The Commissioner of Health then determined which of the actual costs were "allowable", i.e., related to patient care within the meaning of the regulations.

(§86.21) (4) Each facility's "basic rate" was then set at its total allowable costs in the base year, subject to a ceiling of 115% of the so-called "weighted average cost" of all facilities in the particular group. (§§86.11, 86.14(c)) (5) To arrive at the "final" rates**, a "trend factor" was applied to the basic rate to account for cost increases between the base year and the year in which the final rates were to be effective. (§86.15)

(2) The August 1975 Amendments to the Public Health Law

In August 1975, the Legislature enacted amendments to Article 28 of the Public Health Law which, among other things, directed the Commissioner of Health to establish criteria for the evaluation of residential health care facilities and directed him to devise a "rating system" based upon inspection reports. (Public Health Law §2803(1)(c))***

* The base year was generally two years earlier than the year covered by the final rate.

** The rates were "final" in that, other than to correct errors in computation, there were to be no retroactive adjustments. (§86.16)

*** Under Public Health Law §2803(1)(c), the "ratings" based upon the inspections were simply to be posted in each facility, to give the public some information about the facility's atmosphere and quality. The rating system was not designed to measure the reasonable costs of providing health care service, nor was it intended to be applied in establishing Medicaid reimbursement rates. (JA 79-80)

The August 1975 amendments also added to the Public Health Law a new §2808(1)(a), which provided:

"The commissioner shall promulgate interim regulations to expire no later than the thirty-first day of December, nineteen hundred seventy-six, that will relate the rate of payment for each residential health care facility to the operation and program management of the facility, as well as to the quality of patient care provided by the facility. Such regulations shall be consistent with regulations promulgated under the provisions of title eighteen of the federal social security act, by which payment for costs incurred by a residential health care facility for a quantity and quality of supplies or services necessary for the proper operation of a residential health care facility shall not exceed those which would be paid in the normal course of business by a prudent buyer of such supplies or services."

The intended effect, if any, of the "prudent buyer" concept on existing Medicaid reimbursement standards is unclear. Under the applicable federal standard, reimbursement rates were already required not to be "in excess of reasonable charges consistent with efficiency, economy, and quality of care" (42 U.S.C. §1396a(a)(30)); under the applicable State standard, rates had to be "reasonably related to the costs of efficient production" of health care service. (Public Health Law §2807(3))

(3) The "Freeze" of Reimbursement Rates at 1975 Levels

Prior to March 31, 1976, Public Health Law §2807(4) required the Commissioner of Health to notify each residential health care facility of its new annual reimbursement rate "at least sixty days prior to the fiscal year for which the rate is to become effective." For example, on November 1, 1974 each facility was advised of its new rate effective January 1, 1975. On November 1, 1975, however, notice of new rates for 1976, re-

quired by §2807(4), was not given. Instead, each facility was advised that "interim" rates had been "developed" for 1976. (JA 16) The "interim" rates, announced in January 1976, were no more than a restatement of the 1975 rates. (JA 16-17, 50, 60, 70)

The legality of this "freeze" of reimbursement rates at 1975 levels was challenged under State law in Kaye v. Whalen, brought in February 1976. Petitioner in Kaye argued that since the 1975 rates had been certified under §2807(3) as being "reasonably related to the costs of efficient production" of health care service in 1975, and since there had been substantial, undisputed increases in the costs of providing such service between the approval of the 1975 rates and the time that new rates for 1976 should have been determined, the frozen rates necessarily failed to comply with §2807(3). The Petitioner's position was sustained by Special Term, but was rejected by the Appellate Division, in a 3-2 decision presently on appeal to the New York Court of Appeals.*

(4) Chapter 76 of the Laws of 1976

In March, 1976, the New York State Legislature enacted Chapter 76 of the Laws of 1976. This law had as its stated purpose the placing of "controls on medical assistance and public assistance expenditures." Section 11 of Chapter 76 added a new Public Health Law §2807(2)(e):

"During the period beginning January first, nineteen hundred seventy-six, and ending March thirty-first, nineteen hundred seventy-

* The as yet unreported decisions of Special Term and the Appellate Division are Documents Nos. 8 and 9, respectively, in Plaintiffs' Addendum.

seven, the commissioner may determine and certify to the director of the budget rates of payment for residential health care facilities without regard to the provisions of subdivision three of this section. The commissioner is directed to formulate such rates in accordance with the provisions of paragraph c of subdivision one of section twenty-eight hundred three and section twenty-eight hundred eight of this chapter which rates shall be effective for the period hereinbefore specified in this paragraph notwithstanding any inconsistent provision of such section twenty-eight hundred eight."

Thus, solely to achieve Medicaid savings, the Legislature authorized the Commissioner of Health to disregard costs in setting Medicaid reimbursement and directed him instead to formulate rates "in accordance with" the provisions of §2803(1)(c) (which had directed the creation of a rating system for informational purposes) and §2808 (which had directed the promulgation of regulations consistent with the "prudent buyer" regulations under Medicare).

The abandonment by New York of its long-standing commitment to cost related reimbursement led the Commissioners of Health and Social Services to caution the Governor's counsel (JA 89-93), that Section 11 of Chapter 76 created the risk of an impending conflict with §1396a(a)(13)(E) of the federal Medicaid Act (JA 90):

"[B]ill Section 11 raises the possibility that there will be a Federal compliance issue as of July 1, 1976 since, as of that date, federal requirements mandate that nursing home rates be formulated on a cost related basis. To the extent that bill section 11 requires that costs be disregarded, the compliance issue could be raised."

The Commissioners further noted the impossibility of immediately creating and applying a reimbursement system tied to

the §2803(1)(c) rating system: "it [would] take a full year before all residential health care facilities are individually rated", and "it is difficult to use the specific rating categories and other details of §2803(1)(c) at this time". (JA 90) The Commissioners requested an amendment to Section 11 eliminating the direction to formulate reimbursement rates in accordance with the rating system, concluding that, in the absence of such an amendment, "there will be serious question as to our following the letter of the law." (JA 91)

Despite these objections, Chapter 76 was signed into law on March 31, 1976. In so doing, the Governor noted the Commissioners' "serious reservations" about the bill, but declared that "the expenditure savings projected under the bill are essential to achieve a balanced budget, and because of the urgent need to present such a budget for the State of New York, I must sign this measure into law." (JA 95)

(5) The Rating System

The §2803(1)(c) rating system -- which Chapter 76 directed be used for purposes of calculating Medicaid reimbursement -- was, from its inception, unrelated to measuring the costs incurred by residential health care facilities. (JA 79) The rating system utilized criteria capable of yielding only the grossest generalizations about patient contentedness* and quality of services** at particular facilities.

* For example, in October, 1975, when the §2803(1)(c) rating system was being formulated, a Department of Health memorandum, reflecting the criteria to be used stated that the "highest" rating was to be given only if (JA 1010):

"[The] patients [are] treated with dignity and respect . . ."
"[T]here [is] a general atmosphere of hope and cheer"; "[P]atients [are] doing things they find interesting and stimulating"; and
"[P]atients look forward to each new day."

** The criteria for rating specific services to patients
(Footnote continued on next page)

Plainly, Medicaid reimbursement reasonably related to costs could not possibly have been based on such criteria. When these criteria were developed, in late 1975, there was no intention to apply them to reimbursement (JA 80); they were "intended to be the simplest possible and clearest statement that can be made about what the profile is of each of the facilities' major patient care end products." (JA 106)

As of March 31, 1976, when Chapter 76 became law, the rating system, even as limited as it was in its scope, was far from implementation. Despite the statement of the Commissioners of Social Service and Health that it would require a full year before all residential health care facilities were individually rated (JA 90), by May 13, 1976 every facility in the State had somehow been assigned a rating* in each of the following categories: medical care, rehabilitation therapy, social work, nursing, food-nutrition, leisure time activities, cleanliness and safety, and building features. To each of those categories, a rating ** was

(Footnote continued from previous page)
were just as subjective. For example, in rating a facility's nursing services, the health inspectors were directed to determine whether "each resident [is] given the type of care he needs", and whether the resident's relatives and physicians are "kept informed" of his condition and progress. In judging food and nutrition, the health inspectors were directed to determine whether meals were "well prepared and attractively served." In evaluating leisure time activities, the inspectors were to determine whether "interesting" activities and outings were provided. (JA 99-100)

* The record below is barren of any explanation by defendants as to how the Department of Health could possibly have assigned meaningful ratings to every facility in the State in the six week period between March 31, 1976 and May 13, 1976.

** The following ratings were used: "Very Good", "Good-State", "Good-Federal", "Needs Improvement" or "Unacceptable".

assigned, based largely upon the observation of the inspectors who had conducted the most recent inspection of the facility. (JA 20-21)

(6) The Formulation of Regulations Designed to Limit Reimbursement to a Predetermined Amount

Plaintiffs asserted under oath that the Department of Health officials responsible for implementing the rating system and tying it to reimbursement were instructed to limit Medicaid reimbursement for 1976 to 1975 levels (JA 81), and that the Department of Health thereupon set out to develop regulations designed to achieve its predetermined fiscal goal. These allegations went unchallenged by defendants. As would be anticipated, the resulting regulations (first labelled Part 88 and later Part 86-2 of 10 NYCRR*) deviated substantially from the cost related approach of Part 86.

Under Part 86, the "groupings" had been utilized to ensure that each facility was compared to other facilities with similar costs. Thus, facilities were grouped by three significant criteria: number of beds, type of sponsorship (nonprofit or proprietary), and geography. Grouping by type of sponsorship followed from the fact that nonprofit facilities render services to a much sicker patient population than do proprietary facilities**, and therefore necessarily incur greater costs. Because of the intensity of care required for sicker patients, non-profit facilities must hire more registered nurses (as opposed to practical nurses)

* Part 88 appears at JA 113-148. Part 86-2 appears at JA 150-181.

** A 1975 Department of Health report indicated, far fewer patients are discharged to acute care hospitals from nonprofit facilities than from proprietary facilities. (JA 184)

and generally have larger medical and supporting staffs. (JA 84) The significance of grouping by geography is obvious -- the costs of similar goods or services vary greatly throughout the State.

Yet, the new regulation in the form of Part 86-2, designed as they were to reach a particular budgetary result, grouped facilities without regard to sponsorship or geography. (JA 534) After being grouped solely by number of beds, the facilities within each group were subclassified according to the ratings they recieved on May 13, 1976 in five of the categories of rated services: nursing, food-nutrition, leisure time activities, cleanliness and safety, and social work. (JA 534) For example, all facilities with between 100 and 199 beds which received a "Good-State" rating in nursing were grouped together.

Having thus identified and grouped the homes, the Commissioner proceeded to impose reimbursement ceilings for each different service. All facilities other than those receiving a "Very Good" rating for a particular service were subjected to a ceiling based upon a "percentile system". (JA 23-24, 156-157) Facilities receiving a "Good-State" rating for any service were limited in their reimbursement for such service to the amount spent on such service by the residential health care facility at the 60th percentile of all facilities in the group.*

* Facilities receiving "Good-Federal" ratings for any service were limited in their reimbursement for such service to the amount spent on such service by the residential health care facility at the 35th percentile of all facilities which received a "Good-State" rating for such service. Facilities receiving "Needs Improvement" ratings for any service were limited in their reimbursement to the amount spent on such service by the residential health care facility at the 25th percentile of all facilities which received a "Good-State" rating for such service.

In other words, some part of the actual costs incurred by 40% of the facilities receiving a "Good-State" rating for any service, were disallowed in determining the Medicaid reimbursement for such service, regardless of the reasonableness of the cost incurred in providing the service, the efficiency of its production, or the needs of the patients to whom it was provided. Facilities which received ratings below "Good-State" in any category were penalized even more severely.

The particular "percentiles" used to limit reimbursement were selected not because they bore any relationship to the reasonable costs of the services provided, or any notion of a "prudent buyer", but because they yielded the dollar amount of total Medicaid reimbursement decided upon in advance by defendants. Indeed, it was conceded by defendants that they had considered and rejected the use of percentile limitations higher than those chosen (JA 804-805*), because the higher limitations would not have produced the predetermined overall Medicaid reimbursement figure to which they considered themselves limited. As candidly stated by Miss Wall of the Department of Health when asked by the court for the basis of the percentile limitations:

"The basis was that long-term care is costing too much and that it has to be controlled." (JA 765)

(7) The Promulgation of Parts 88 and 86-2 and the November 1 Rates

Having satisfied himself that the "grouping" and "percentile" limitations described above would yield the desired fiscal result, on September 30, 1976 the Commissioner of Health promul-

* The statement "And the 85th and 90th" at JA 805 is incorrectly ascribed to the court. The statement was made by Miss Wall of the Department of Health.

gated 10 NYCRR Part 88 embodying the methodology of relating reimbursement to rating, to replace Part 86. (JA 25)

The Commissioner of Health purported to make the adoption of Part 88 effective immediately, dispensing with the mandatory 21-day prior notice period provided for in State Administrative Procedure Act §202.2(a), by describing Part 88 as an "emergency" measure under Section 202.2(c) of that Act. (JA 25) The "finding" necessary to support the immediate effectiveness of Part 88 was based upon the following "reasons" (JA 190):

"The expenditures of the State Department of Social Services currently exceed budgeted amounts for the 1977 fiscal year . . . ;

[I]t is imperative that . . . [the] methodology for computing rates for . . . [residential health care] facilities be altered so as to assure fiscal economies immediately; [and]. . .

[In] litigation currently pending, a lower court has determined that the current ["frozen"] rates applicable to residential health facilities are invalid insofar as such rates are subject to a statutory mandate which preexisted the authority given in Chapter 76 of the Laws of 1976 and, in order to mitigate the potential threat of such a decision to the general welfare, it is necessary to promulgate this regulation immediately."

On October 12, 1976, the Department of Health gave notice pursuant to State Ad. Proc. Act §202.2(a) of the adoption of what was now called "Part 86-2" of 10 NYCRR. Part 86-2 was in all material respects the same as Part 88. (Compare JA 113-148 with JA 150-181) Afforded the opportunity for the first time to comment on the changed methodology for rate calculation, the two plaintiff associations filed a statement opposing proposed Part 86-2. (JA 26) Nevertheless, on or about November 1, 1976 -- before the expiration of the 21-day comment period -- the Department of Health announced new reimbursement rates, effective immediately, and retroactive

to January 1, 1976* (JA 26-27), calculated under the purported authority of Part 86-2. As noted above, the new rates effected reductions in the existing rates (which had already been frozen at 1975 levels) of over 60% of the plaintiff class. (JA 76) Although the new rates were not publicly announced until November 1, 1976, defendants admitted that the rates had actually been fixed by September 29, 1976 (JA 207) -- the day before the new regulations were filed as an "emergency" measure -- further exposing the new regulations as window dressing designed solely to disguise predetermined rates.

The Proceedings Below

On November 19, 1976, plaintiffs moved for a preliminary injunction to enjoin the implementation of the new regulations and November 1 rates insofar as the rates effected reductions in the rates plaintiffs and the members of the class were receiving as of October 31, 1976. (JA 45-48)**

(1) The Uncontradicted Factual Showings Made by Plaintiff

The grave economic harm which the implementation of the rate reductions would have on the members of the plaintiff

* In retroactively applying the new rates, defendants proposed to recoup from facilities that had their rates reduced on November 1 the alleged "overpayments" received by such facilities between January 1 and October 31. The retroactivity issue is not involved on this appeal since the court below was assured by defendants that the new rates would not be applied retroactively without prior notice to the Court. (JA 2149-2150)

** When this action was commenced, no facility had as yet received reimbursement at the new, reduced rates, since Medicaid reimbursement payments are generally not made to providers of Medicaid services until at least several weeks after the month in which the Medicaid services are rendered. By reason of the denial of the preliminary injunction below, most facilities in the class have now received at least three monthly payments at the challenged rates.

class is attested to in affidavits in support of the preliminary injunction motion (JA 49-190), and in the testimony of representatives of each of the five named plaintiffs on December 7, 1976. (JA 717-923) Thus, Mr. Fischer of St. Cabrini, a 200-bed skilled nursing facility, testified that St. Cabrini's actual costs per patient day for 1976 were \$69.33, that its Medicaid reimbursement rate prior to November 1, 1976 had been \$62.51 per patient day and that its new rate announced on November 1 would be \$55 per patient day. (JA 729, 739-740) Mr. Fischer testified that even under the \$62.51 rate in effect since 1975, St. Cabrini was four months behind in payments to its suppliers, despite substantial efforts to reduce costs by not filling vacant positions and by careful review and revision of its buying practices. (JA 739, 757-760) Mr. Fischer stated that under the new rates St. Cabrini would incur cash losses of approximately \$30,000 per month and that within approximately 60 days it would have great difficulty even in meeting its payroll. (JA 750-751)

Similar testimony was given by Mr. Glaser of the Margaret Tietz Center, a facility with 120 beds in the skilled nursing category and 80 beds in the intermediate care category: Margaret Tietz's actual costs per patient day for 1976 were \$72.67 in the skilled nursing category and \$50.36 in the intermediate care category, its Medicaid reimbursement rates in each category prior to November 1, 1976 were \$68.46 and \$41.42 per patient day, respectively, and that its new reduced rates announced November 1 would be \$51.38 and \$35.08 per patient day. (JA 897-899) Mr. Glaser testified that Margaret Tietz had been able to achieve cost savings by reducing the use of utilities, eliminating certain laundry

services and revising its buying practices (JA 902-903), but notwithstanding these savings, the new rates would have a devastating impact on operations (JA 901-902):

"We would probably be able to operate sometime into March before we would have to close.... Our nursing staff...would have to be reduced from 102 people to 45 people to render care to 200 patients on a 24-hour basis seven days a week, including relief and vacation, the net effect of which is very serious and would jeopardize the lives of my patients."*

To demonstrate that the losses and financial hardships testified to by the named plaintiffs were typical of those that would be suffered under the new rates by class members throughout New York State, plaintiffs submitted an affidavit (JA 222-224)**, which contained a list of every nonprofit facility whose rate was reduced on November 1 and the amount of the reduction; and set forth more detailed information regarding the immediate cash losses that would be incurred as a result of the new rates, by a sample of 20 members of the class.***

Plaintiffs' affidavits and testimony, demonstrating that the hasty imposition of reduced rates on November 1 would create widespread financial difficulties resulting in substantial cuts in patient care or outright closings of facilities, were never challenged by defendants. On the contrary, defendants acknowledged that the new rates would require massive reductions in existing levels of operations, and "recommended" cuts that de-

* See also the similar testimony relating to plaintiffs Lorreto Rest (JA 823-858), Mohawk Valley (JA 868-873), and Daughters of Sarah (JA 914-923).

** The exhibits to this affidavit are not included in the Joint Appendix; they are available in the original record.

*** The losses for some facilities exceeded \$1 million.

defendants claimed could be made -- "recommendations" that had never been suggested to plaintiffs before the commencement of this litigation, and which were nothing more than after-the-fact attempts to rationalize the challenged rates. At the hearing on December 10, 1976, when Dr. Cicero, testifying on behalf of defendants, announced that St. Cabrini could continue operating under the new rates by immediately firing enough nursing and other staff to achieve an annual savings of \$620,000 (JA 1325), the following exchange took place (JA 1327):

"THE COURT: Has the Department of Health or has anybody else representing the State of New York ... before this afternoon on this witness stand apprised the St. Cabrini Home of this position or anything similar to it?

THE WITNESS: Not to the best of my knowledge"

Apart from the fact that defendants' "recommended" cuts had never been suggested prior to the November 1 rate reductions and the ensuing litigation, the impact of the cuts on patient care would be disastrous. Beth Abraham Hospital Nursing Home, informed by the Department of Health on January 19, 1977 that it should immediately cut \$2.5 million from its budget of \$13 million, advised the Department that:

"...the recommended cuts go far beyond any existing rules and regulations governing the operation of the institution, and would irreparably harm the functioning of this institution in its ability to meet patient's needs. Most significantly, however, it is our firm belief that were these cuts to be instituted at Beth Abraham Hospital there would be significant numbers of patient deaths directly attributable to these proposed staffing changes." (JA 253-254)

Similarly, Mohawk Valley Nursing Home, upon being told

by the Department of Health, among other things, that in order to accommodate its reimbursement reductions it should immediately eliminate 20 of its 80 nursing positions, advised the Department by letter dated January 28, 1977 that such a dramatic reduction in nursing staff:

"... would reduce the level of patient care to the warehousing of human beings. We cannot, and will not, tolerate Nursing Home residents being forced to lay in their own urine and feces because nursing time is not available to promptly care for them. The decubiti caused by this neglect would require further nursing time leading to additional neglect. The multiple compounding of problems is obvious." (JA 391)

The record below will be searched in vain for any affidavit or testimony on behalf of defendants even responding to, let alone challenging, these assertions of danger to the very lives of patients that would flow from implementation of the cuts necessitated by the new rates. Nor does the record contain any facts submitted by defendants to show that the costs incurred by the named plaintiffs, or any member of the class, were excessive, unreasonable or reflected any inefficiency in operation.

(2) The District Court's Treatment of the Application

The hearings on the preliminary injunction and related court-ordered conferences and meetings spanned a period of some three months. The 800 transcript pages reflect no fewer than ten hearing dates, devoted more to court-initiated colloquy than to testimony. The court vacillated in its views, between considering preliminary injunctive relief on a class-wide basis inappropriate, to acknowledging that class relief was the only feasible

approach.* Indeed, it either suggested or demanded, on no fewer than ten occasions, that the State voluntarily agree to a stay of the November 1 rates on a class-wide basis, for periods ranging between 30 days and 5 months. (See e.g., JA 708, 878, 1445, 1452-53, 1587-88, 1590-91, 1646, 1723)

*The court stated (JA 1579-1581):

"In my own thinking about this, I have gone back and forth in my thought process between thinking that we can't give any relief in any event, except on an individual basis. I have thought that at times and then I have thought at times that it is [im]practical to deal with it on an individual basis because if you get into the individual situation, it could take an endless amount of time and that might in itself work its own injustice and hardship.

Furthermore, this has been brought as a class action and one -- although there are some formalities about class action we haven't gone through, one must assume that there is some reliance on this action by the associations and their members.

So I have a lot of things going around in my mind.

I don't really know the situation at . . . any homes that have [not] come here before me with financial information. I recognize that. That is a problem.

On the other hand, if I don't have information to the contrary, I would presume that in a period of the economy such as ours, which is still generally inflationary, I would sort of presume that when you cut rates, you create some problems. I am putting that in a general kind of a way, because I don't know the details.

When I made the suggestions I did, I was thinking of across the board, and this is the reason, that although I don't know the details of all of the homes, I have received some samples, and, in any event, there are some common problems.

One, nobody got prior notice of their rate cuts, so that problem is common to everybody.

Secondly, to the extent that someone is cut, that in itself I must assume creates problems as I have said.

(Footnote continued on next page)

The demands and suggestions were no more than that. Until the denial of the injunction almost three months after the making of the motion, the sum total of the court's action was to require the parties to "cooperate". The court's sole objective seemed to be to relieve itself of its obligation to come to grips with the serious and fundamental issues raised by the litigation. In short, for three months the court avoided its obligation to function judicially while denying the plaintiffs' access to this Court.

In the face of the State's continued refusal to take any voluntary action, and plaintiffs' urgings that the case be dealt with by the court in the same fashion as all other litigation, the court refused to involve itself with the substantive issues con-

(Footnote continued from previous page)

I would like to have a device so that there can be some sensible solution to this problem that is both quick and can be carried out, if not tonight, very, very quickly. I think that is in itself desirable.

Secondly, I would like to see a device where we can make use of the knowledge gained but we don't have to just spend immense labor going over case by case hundreds of homes.

That is simply not practicable.

I couldn't do it. [This paragraph is incorrectly ascribed in the transcript to Dr. Cicero.] The only way that could be done is to have probably really a number of special masters appointed. If the Court was to take a part, that would involve expense, even that would be unworkable and slow. So that to take the five people and give them special treatment I don't think is a very good idea, and to try to deal with everybody individually I think is impractical.

So I really think we have to do it on a group basis." (Emphasis added.)

cerning the illegality of the rates.* Instead, it abruptly terminated cross examination of the State's first witness with the observation that plaintiffs' counsel and the court had "different ideas about what should be done here", and directed that the Department of Health meet with the named plaintiffs and present to them any suggestions it might have about cost savings. (JA 1387)

Such meetings were held, but the failure of defendants to do more than insist that plaintiffs make whatever cuts were required by the new rates compelled plaintiffs to turn again to the court for relief. Hearings resumed on December 17. (JA 1403-1600) At the next hearing, on December 21, the court was informed by defendants' counsel that the November 1, 1976 rates would be increased, as of January 1, 1977, by an inflation factor of 4 to 5 percent. (JA 1648-1649) The court was immediately advised by plaintiffs that this so-called "trending" did not represent any effective increase to the homes, since there were mandated labor costs which were to increase as of January 1, 1977, so that the reduction and loss caused by the November 1 rates would not be materially changed by any adjustment for inflation or increased cost as of January 1, 1977. (JA 1657-1658)

Nevertheless, rather than proceed to the merits of the case, the court's response was to state that the January 1, 1977 rates needed further analysis. On the basis of "assurances" by the defendants that they would give consideration to granting some voluntary relief to facilities facing grave financial hardships, the

* For example, the court stated: ". . . I do not really intend to get into the merits of different rating systems." (JA 1452)

court, once again, decided to take no action on the application for injunctive relief. Counsel for plaintiffs was directed to "obtain", with respect to the class, "situations where there are cases of financial emergency or critical need created by the reduction in rates...", and to "screen" situations involving critical need from those which did not involve such need, and to present that information to the Department of Health. (JA 1767-1768)

The farce that followed was one that could reasonably have been expected when plaintiffs are directed, in effect, to seek their remedy from the very party alleged to have caused the injury. Representatives of the plaintiff class met in Albany with representatives of the Department of Health, and this procedure was followed (JA 238):

The deficit each facility faced as a result of the precipitous rate reductions was calculated, and representatives of the Department of Health purported to "demonstrate" to each facility how services provided by that facility could be reduced to wipe out the deficit. This process included directions by the Department of Health to cut staff for programs with respect to which members of plaintiff class had only recently been told -- by the Department of Health -- to increase staff. The reaction of most of the facilities affected can be summarized by that of Beth Abraham Hospital Nursing Home, which stated (JA 253-254): it is our firm belief that were these cuts to be instituted at Beth Abraham Hospital, there would be significant numbers of patient deaths directly attributable to these proposed staffing changes."

Accordingly, when it became apparent that the review process was inadequate, and that the January 1 "trending", even if implemented, would still leave over 100 homes with rates reduced below the pre-November 1, 1976 rates, plaintiffs requested a hearing to ask the court to act upon, by granting or denying, the motion in its original form -- for an injunction against all post-November 1, 1976 rates insofar as they were lower than pre-November 1, 1976 rates.

The hearing was held on February 4, at which time the court was advised by plaintiffs that the record was complete. Plaintiffs noted that the court-ordered review by the Department of Health had resulted in an assurance of some relief to only one of the initial thirteen homes slated for review, and even this promise had been defaulted upon (JA 1822, 1828-1830), and that, even if there had been specific relief in individual cases, the injunction would still have been required because of the ongoing cuts in services throughout the State, caused by the lower reimbursement rates. (JA 1829) Counsel for plaintiffs concluded with a plea for a decision (JA 1878):

" . . . I must ask that you enter an order, we would hope, granting the injunction as requested, but if you feel that you cannot do that, then denying it at the earliest possible time. The situation is that bad."

The court then accused plaintiffs' counsel, in a statement utterly belied by the record of these proceedings (JA 1878):

"You have let this thing dangle from December 22.

. . . Now, you cannot possibly expect to have a determination in a complicated thing like this, you cannot expect it in less than a week or ten days. I mean, it is an impossibility."

In bringing the hearing to a close, the court stated (JA 1879):

"Now, if in the meantime some particular nursing home is literally about to close, I will hear about that."

Another hearing was held on February 9, 1977. Plaintiffs were prepared to offer additional testimony to demonstrate the variety of conditions crying out for quick action -- or any action -- by the court below.

But, the proceedings re-traveled a route that had become all too familiar. Representatives of three facilities testified. With respect to the first facility, plaintiff Loretto Rest, the State had, in the course of its review process, agreed to some increase in rates, but the facility still contended that it needed a higher rate simply to meet its payroll, ignoring for the moment the fact that it was four months behind in its mortgage payments and had received a letter threatening foreclosure. After lengthy colloquy, the court concluded that it was "mandatory" that the Department of Health and Loretto "get together immediately . . . and find out what the differences are if any. . . ." (JA 1957)

As to the second facility (class-member Mary Manning Walsh), it turned out that for reasons apparently unrelated to this action, a recognition by the State of additional patient capacity in the facility would result in a higher rate. The court thereupon directed officials of both the Department of Health and the Budget Department to go to such home immediately and supervise the counting of beds, and demanded a report the next day. (JA 2002-2003)

A representative of a third facility, Plaza Nursing Home, began to testify, but the State claimed that it was in the process of a "review" of Plaza and the court thereupon deferred further consideration of that facility.

As the court was preparing to bring the day's proceeding to a close, again without focusing upon the fundamental issues or the continuing harm to the class and its patients, counsel for plaintiffs once again restated plaintiffs' request for relief (JA 2020):

" . . . [Y]our Honor, the problems that we have in this class action transcend these individual cases, and I think that since November 19 we have seen a process that your Honor has suggested that we meet with the state. When we appear in court, there are new statements made by the defendants and new things are disclosed for the first time and we are sent back to discuss with them and see where we can go from here. But at this point, your Honor, on behalf of the class that we represent, we are prepared to rest on the record as it is now."

The court responded sharply by denying the injunction from the bench, and stating alleged "findings and conclusions" which are refuted by virtually every relevant fact in the record (JA 2020):

"Then I will tell you right here and now that I will deny the motion for preliminary injunction on a class basis. I do so on the basis of the record that demonstrates to me that when the facts are gone into as to the individual homes, there is a wide and substantial discrepancy as to the issues as to each individual home."

The "discrepancy" referred to by the court is not disputed by plaintiffs, but it has no impact whatever on the similarities among all facilities suffering reductions which require preliminary injunctive relief, as the court itself recognized on several

occasions.

As to the so-called findings and conclusions (JA 2020-2021): First, the court stated "[t]he record amply demonstrates that there are differences in the rates granted to the homes." The relevance of the fact that costs, and therefore rates, vary from home to home, is neither apparent nor anywhere explained.

Second, the court stated "[t]here are differences with respect to the procedures engaged in by the Department of Health and the Department of the Budget with respect to these homes." The procedures to which the court referred were reviews and meetings that took place after the challenged rates were put into effect without notice to any facility. They have no bearing whatever on the underlying claim for relief.

Third, the court stated "[t]here are differences, substantial differences in the financial condition of the different homes." By emphasizing this "finding" the court demonstrated its fundamental misconception that irreparable injury could be established only if a facility were in such dire financial straits that it would soon go out of business if the injunction did not issue. Apparently lost on the court was the fact that even graver injury could be presented by a facility's staying in business only on the basis of massive reductions in services which impair needed and life-sustaining medical treatment.

Finally, the court "found" that "[t]here are substantial differences in the effect of the various rates." This plaintiffs cannot dispute. Facilities with larger cuts were required to make

greater reductions in services; facilities with smaller cuts did not have to make as many reductions in services. However, pending final determination of the legality of the the challenged rates, all facilities facing reductions were and are being required to make drastic and dangerous cuts in services to their patients.

POINT I

THE CHALLENGED REGULATIONS ARE INVALID BECAUSE THEY DO NOT PROVIDE REIMBURSE- MENT ON A REASONABLE COST RELATED BASIS

A. The Development of the "Reasonable Cost Related" Standard

As noted above, prior to July 1, 1976 there was no federal standard mandating a specific level of reimbursement to residential health care facilities rendering services to Medicaid-sponsored patients. There were, however, several federal statutes and regulations which applied to the reimbursement of such facilities.

Skilled nursing facilities rendering services to patients covered by the wholly federally funded Medicare Program, were, by statute, entitled to be reimbursed at the lesser of the "reasonable cost of such services" or the "customary charges" with respect to such services. 42 U.S.C. §1395f(b). "Reasonable cost" was defined as "cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services." 42 U.S.C. §1395x(v)(1)(A). Since "reasonable cost" under Medicare reimbursement is based upon "actual" costs, it necessarily entails retrospec-

tive reimbursement on an institution-by-institution basis.*

Under the Medicaid program, as opposed to Medicare, reimbursement methodology was left to the states, which were free to set reimbursement at whatever level they chose, subject only to two specific federal limitations. The first was the one imposed by 42 U.S.C. §1396a(a)(30), that a State Plan must:

"provide such methods and procedures relating to the ... payment ... for care and services available under the plan ... as may be necessary to assure that payments ... are not in excess of reasonable charges consistent with efficiency, economy, and quality of care."

The second limitation is found in the regulations adopted by the Secretary of HEW to implement §1396a(a)(30), which provide that if a facility renders services to both Medicare-sponsored and Medicaid-sponsored patients, the Medicare reimbursement rate is the upper limit for such a facility's Medicaid reimbursement rate. 45 C.F.R. 250.30(b).**

In 1972, when Congress was considering amendments to the Social Security Act, it focused upon the defects inherent in the failure to have provided for Medicaid reimbursement on a cost related basis. Thus, the report of the Senate Committee on Fi-

* Thus, every skilled nursing facility rendering services to Medicare sponsored patients is required to maintain detailed service and financial records which are subject to post-period audit to determine the specific reimbursement rate for the period covered by such records. See 20 C.F.R. §405.453.

** This limitation has been upheld primarily on the ground that the terms "reasonable cost" under §1395(x)(v)(1)(A) and "reasonable charge" under §1396a(a)(30) were intended by Congress to have virtually identical meanings. See Opelika Nursing Home, Inc. v. Richardson, 356 F. Supp. 1338 (M.D. Ala. 1973), aff'd sub nom. Johnson's Professional Nursing Home v. Weinberger, 490 F.2d 841 (5th Cir. 1974).

nance observed that, under Medicaid, states generally established, in advance, per diem or similar basic rates payable for patients receiving nursing facility care. This "flat-rate" approach, as contrasted with the computation of actual cost involved in the Medicare reimbursement formula, had led to expressions of concern that "some [nursing facilities] are being overpaid by Medicaid, while others are being paid too little to support the quality of care that Medicaid patients are expected to need and receive." (S. Rep. No. 1230, 92d Cong., 2d Sess. 287 (1972))

In seeking to remedy this by requiring reimbursement on a cost related basis, the Committee rejected the strict "reasonable cost" approach of the Medicare program because "[t]he detailed and expensive cost-finding requirements can prove cumbersome." Id. It therefore settled upon a proposed amendment to the Social Security Act in the form of 42 U.S.C. §1396a(a)(13)(E), containing the requirement that states reimburse facilities on "a reasonable cost-related basis". This was intended to give the states the option of either computing rates on an institution-by-institution basis, as under Medicare, or on some reasonable class basis which would not involve the expensive cost finding mechanism inherent in the Medicare methodology, so long as the methodology was designed to produce rates corresponding to the reasonable cost of services rendered by members of the group:

"The Committee does not intend that this provision [42 U.S.C. §1396a(a)(13)(E)] should require use of the specific medicare reasonable cost reimbursement formula by States for purposes of reimbursing skilled nursing homes and intermediate care facilities under medicaid, although States are free to choose this option. Rather, the States could develop other reasonable cost-

related methods of rate-setting." (Ibid.)

This legislative history demonstrates beyond dispute (and we do not understand defendants to dispute) that as of July 1, 1976* states were required to develop a reimbursement methodology which would be designed to pay such facilities in full their actual allowable costs reasonably incurred in providing covered services to Medicaid-sponsored patients.

The legislative history is consistent with federal regulations imposing on providers of Medicaid services, obligations which would be justifiable only if providers were assured of recovering reimbursement for actual reasonable costs. For example, residential health care facilities participating in Medicaid must accept, as payment in full for services rendered to Medicaid eligible patients, the amount reimbursed under the Medicaid program. (45 C.F.R. §250.30(a)(8)).** Moreover, the costs of rendering services to Medicaid-sponsored patients may not, as a matter of Congressional intent, be imposed on non-Medicaid patients; this would necessarily be the result of any reimburse-

* Although §1396a(a)(13)(E) as formulated by the Senate would have required cost related reimbursement by July 1, 1974, the bill emerged from conference with an amendment changing the effective date to July 1, 1976. See S. Rep. No. 1605, 92d Cong., 2d Sess., reprinted in [1972] U.S. Code Cong. & Ad. News 5389-90.

** As noted above, as of July 1, 1976, the date on which the "reasonable cost-related" standard became effective, State Plans could no longer utilize "supplementation" programs in compensating facilities. Congress had specifically permitted supplementation to continue up to that date only if the payments by the particular state "are less than the reasonable cost of the care and services provided." S. Rep. No. 744, 90th Cong., 1st Sess. 187-88, reprinted in [1967] U.S. Code Cong. & Ad. News 3026.

ment program which did not seek to provide reimbursement that approximated the actual, reasonably incurred costs of rendering services to Medicaid-sponsored patients.*

Accordingly, as of July 1, 1976, although the particular Medicaid reimbursement methodology adopted by a state need not have guaranteed that every facility would, at year's end, have actually been reimbursed for every dollar spent by it on services to Medicaid-sponsored patients** the methodology utilized had to be designed to approximate the actual, reasonably incurred costs of rendering services to such patients.

This is further confirmed by the regulations promulgated by the Secretary of HEW on July 1, 1976, with respect to 42 U.S.C. §1396a(a)(13)(E), the preamble to which states that:

"[T]he statutory requirement of 'payment... on a reasonable cost related basis' must mean that, after determining the reasonable cost on the basis of some approved method, the State must set a payment rate that it finds adequate to reimburse such reasonable costs...." (41 Fed. Reg. 27302 (July 1, 1976))

Although the regulations recognize that there may be many formulae which yield reimbursement figures within a "reasonable" range, two methodologies are specifically prohibited:

* See Connecticut State Department of Public Welfare v. Department of Health, Education, and Welfare, 448 F.2d 209, 213 (2d Cir. 1971), quoting H.R. Rep. No. 213, 89th Cong., 1st Sess. 32 (1965): "[It] was the intent of Congress that 'the costs of services of individuals covered by the program will not be borne by individuals not covered.'"

** Such a guarantee would preclude a rate promulgated on a "group" basis.

1. "[A] State would not satisfy the requirement of [42 U.S.C. §1396a(a)(13)(E)] if it paid, or gave an assurance to pay, the amount determined under this section to the extent that State funds are available, or to the extent that State appropriations permit" (Id. at 27303) and
2. "[T]he State may not set the payment rate at, for example, 60 percent of reasonable costs; such a rate, although it would be within a literal definition of the words 'payment on a reasonable cost related basis,' would not comport with what Congress clearly understood to be the meaning of the statutory language." (Id. at 27302)

B. Illegality of Methodologies Deviating from the Statutory Standard

Because the "reasonable cost-related basis" standard of §1396a(a)(13)(E) has so recently become effective, we have found no decisions dealing with a challenge to Medicaid reimbursement rates as failing to comply with it. There is, however, no paucity of pronouncements by the United States Supreme Court that, when federal funds are allocated to public assistance programs administered by the states, those funds must be "expended in consonance with the conditions that Congress has attached to their use." E.g., Rosado v. Wyman, 397 U.S. 397, 423 (1970).

Moreover, this Court, and many others, have considered challenges to state reimbursement methodologies under Medicaid, in particular the "reasonable cost" standard applied to hospital services under §1396a(a)(13)(D). The principle which emerges from those cases is that when a state is obligated, as a condition of Medicaid participation, to formulate reimbursement rates for particular services on a cost related basis, it must make a bona fide

effort to do so, dealing with the actual costs of the services allowed, and may not, so long as it wishes to participate in the Medicaid program, permit state budgetary or fiscal considerations to dictate the methodology or reimbursement rate ultimately determined.

The leading case on this subject is Catholic Medical Center of Brooklyn and Queens, Inc. v. Rockefeller, 430 F.2d 1297 (2d Cir. 1970), aff'g 305 F. Supp. 1256 and 305 F.Supp. 1268 (E.D.N.Y. 1969), appeal dismissed, 400 U.S. 931 (1970). In that action, commenced by two hospitals on behalf of themselves and all charitable hospitals in New York, plaintiffs challenged the State Legislature's 1969 "freeze", of Medicaid reimbursement rates at 1968 levels for in-patient hospital services. Plaintiffs alleged that the statute mandating the "freeze" violated the Supremacy Clause of Article VI of the United States Constitution because of its conflict with 42 U.S.C. §1396a(a)(13)(D), and the regulations promulgated thereunder, which required reimbursement of the "reasonable cost" of rendering such hospital services.

There was no dispute about the impact of the freeze on plaintiffs. Evidence was submitted that plaintiff St. Mary's Hospital's certified 1968 rate per patient day was \$69.55, its actual cost per patient day in 1968 was \$75.51, and that its actual cost per patient day in 1969 was \$88.43 -- almost \$19 above its "frozen" 1968 rate. Although no specific dollar losses for other facilities could be identified with certainty, the court was convinced "that the effect of the statutory freeze on hospitals serving Medicaid pa-

tients is very substantial." 305 F. Supp. at 1262.

The legislative finding on which the freeze was based "cited rising hospital costs, disparities in cost and the need for eliminating the inefficient management as making it essential to establish a cost control program for hospitals." 305 F. Supp. at 1262. In defense of the freeze, the State pointed to the extreme burdens, beyond original expectations, that the Medicaid program had placed on the State budget and argued that the freeze was "necessary" in order to eliminate inefficient practices and initiate a program of cost control in the hospitals.

The court rejected both justifications for the freeze. On the issue of budgetary constraints, the court observed that "[l]ack of funds has not been recognized in earlier cases as a ground for disregarding Social Security Act standards." 305 F. Supp. at 1264. With respect to the claimed "efficiencies" sought to be effected by the freeze, it was noted that:

"[a]ttention to efficiency and cost control is nothing new. The Social Security Act requires that the state plan provide procedures 'to assure that payments...are not in excess of reasonable charges consistent with efficiency, economy, and quality of care.' 1396a(a)(30)." (305 F. Supp. at 1265)

The court also noted that the Commissioner of Health's determination of hospital reimbursement rates in 1968, in light of the prevailing State standard under Public Health Law §2807(3), must have involved a finding that the rates were reasonable and were not inflated by inefficient operations or improper costs. 305 F.

Supp. at 1265.

The principles which were applied in Catholic Medical Center to invalidate Medicaid reimbursement methodologies and rates found not to be in conformity with federal standards, have uniformly been applied by all courts considering the issue. In Massachusetts General Hospital v. Sargent, 397 F. Supp. 1056 (D. Mass. 1975), the State acknowledged that it owed plaintiffs specific sums for Medicaid reimbursement in prior years, but claimed its current legislative appropriations did not permit current Medicaid monies to be paid to hospitals on account of prior years' obligations. As a result, the hospitals were required to borrow or otherwise put up funds for the purchase of goods and services utilized in the Medicaid program well before receiving reimbursement from Massachusetts. In entering a declaratory judgment, the court held:

"[S]o long as the Commonwealth of Massachusetts participates in the Title XIX Medicaid program, federal law requires that the Commonwealth promptly pay the full and actual reasonable costs of inpatient care rendered by providers such as [plaintiff] and the other providers. Any failure to do so, regardless of the reason, is a violation of the Social Security Act."
(397 F. Supp. at 1062)

See also Connecticut State Department of Public Welfare v. Department of Health, Education, and Welfare, 448 F.2d 209, 214 (2d Cir. 1971) (a state policy contrary to the federal statute involved is invalid, "whatever the ... justification for [the] policy....")

In New Jersey Hospital Ass'n v. Klein, Civil Action No. 76-64 (D N.J., April 9, 1976) (Plaintiffs' Addendum, Document No. 11) the acting Commissioner of the Department of Institutions and

Agencies issued a rule that 1976 Medicaid reimbursement rates to hospitals were limited to a 6.7% increase over the 1975 rates, a figure which apparently represented the amount of money deemed available for in-patient hospital services within the constrictions imposed by the state budget. The court therefore held that:

"The ceiling, on its face, is patently arbitrary in terms of any relation it has to reasonable cost levels. Obviously -- and particularly during an inflationary period -- a reimbursement plan cannot establish an arbitrary ceiling on increases in payments, and still purport to be based on reasonable costs."*

See also California Hospital Ass'n v. Obledo, Civ. No. 76-903-R (C.D. Cal., Nov. 5, 1976) (Plaintiffs' Addendum, Document No. 10) (Both freeze and flat 10% per annum allowable increase in reimbursement for services held invalid as not providing reimbursement on a "reasonable cost basis", despite approval of latter by Department of HEW); Wisconsin Hospital Ass'n v. Schmidt, 1976-3 CCH Medicare and Medicaid Guide ¶27,818 (E.D. Wisc. 1976) (Declaratory judgment and permanent injunction granted against Wisconsin rate "freeze", as being in violation of §1396a(a)(13)(D)).

C. The Relevant Authorities Demonstrate the Invalidity of the Challenged Regulations and Rates

- (1) The regulations are invalid because they were promulgated solely to achieve pre-determined fiscal goals.

* Despite its holding on the issue of likelihood of success on the merits, the court declined to issue the injunction because defendants had represented that they were prepared to make the appropriate retroactive payments to the hospitals should the court, at trial, hold the ceiling rule to be illegal. Thus, the Eleventh Amendment problem inherent in directing a state to make retroactive payments, presented by Edelman v. Jordan, 415 U.S. 651 (1974), was not present.

Since 1969, New York has determined Medicaid reimbursement rates under a standard which complies precisely with the federal standard in §1396a(a)(13)(E): under Public Health Law §2807(3), only those costs certified as being "reasonably" and "efficiently" incurred have been reimbursed. To achieve budgetary savings, and for no other purpose, the State enacted Chapter 76 of the Laws of 1976, which eliminated the Public Health Law §2807(3) standard, so that the Commissioner of Health could determine rates to yield a total Medicaid budget within predetermined limits. That the resulting rates could not be claimed to be "cost-related" is manifest.

Defendants Whalen and Toia advised the Governor that the provision authorizing the disregard of costs "raises the possibility that there will be a federal compliance issue as of July 1, 1976 since as of that date, federal requirements mandate that nursing home rates be formulated on a cost-related basis." (JA 90) Nevertheless, despite the "serious reservations about the bill" expressed by defendants Whalen and Toia, the Governor signed Chapter 76 into law, because (JA 95):

"The expenditure savings projected under the bill are essential to achieve a balanced budget, and because of the urgent need to present such a budget for the State of New York, I must sign this measure into law."*

* The deficiencies of the bill were so apparent to the Governor that his approval message expressed his "determination" to put before the legislature a number of proposed changes "to insure that the Medicaid program in this State can be effectively and fairly administered." (JA 95)

The "findings" upon which the "emergency" promulgation of the challenged regulations was based, were acknowledged to be the need to hold expenditures to previously budgeted amounts:

"The expenditures of the State Department of Social Services currently exceed budgeted amounts for the 1977 fiscal year, resulting in a potential threat to the State's ability to obtain financing including the financing of the Medicaid program. Inasmuch as expenditures for long term [residential health care] facilities are the largest single identifiable component of that Department's expenditures, it is imperative that the methodology for computing rates for such facilities be altered so as to assure fiscal economies immediately." (JA 190)

In light of the above, it is not surprising that defendants offered no facts to contradict plaintiffs' assertions that (a) the budget for Medicaid reimbursement to health care facilities was predetermined, (b) the rates necessary to reach the predetermined amount were then calculated, and (c) the regulations necessary to authorize such rates were then promulgated.

Indeed, the evidence offered by defendants merely confirmed them. According to an affidavit submitted by defendants (JA 207), the Department of Health promulgated the new rates for residential health care facilities "on or about September 29, 1976" -- one day before promulgation of the regulations which were supposedly to form the basis for certification of the new rates. The testimony of Miss Wall of the Department of Health, confirmed that the "percentiles" chosen for ceiling limitation purposes were chosen for purely fiscal reasons by acknowledging that higher percentiles were considered and rejected because they produced rates that were too

high.. (JA 804-805; 765)*

To avoid having to comply with the federal reimbursement standard New York could, of course, have withdrawn from the Medicaid program. It then could have set reimbursement rates at whatever level it chose so long as those rates were not unconstitutional on some basis not here presented. But, so long as it continues its participation in the Medicaid program, the funds it receives are required to be "expended in consonance with the conditions that Congress has attached to their use." Rosado v. Wyman, 397 U.S. 397, 423 (1970). Accordingly, since Part 86-2 does not, and was not designed to provide reimbursement to residential health care facilities on a "reasonable cost-related basis", it is invalid by reason of the Supremacy Clause, Article VI of the United States Constitution.

- (2) Wholly apart from its impermissible budgetary origin, Part 86-2 does not provide for Medicaid reimbursement on a "reasonable cost-related basis."

An analysis of part 86-2 and the challenged reimbursement rates themselves, even apart from the fact that they were designed** to produce a specific fiscal result, demonstrates their failure to comply with the "reasonable cost-related" standard.

* In view of this evidence, the declaration by the Secretary of HEW, that a state would not satisfy 42 U.S.C. §1396a(a)(13)(E) "if it paid, or gave an assurance to pay, the amount determined under this section to the extent that State appropriations permit," (41 Fed. Reg. 27303 (1976)) might well have been framed with respect to the specific promulgation of Part 86-2.

** While appellants are mindful that "[s]peculation as to legislative and executive motive is to be shunned", Rosado v. Wyman, 397 U.S. at 419, in the instant case the "legislative and executive motive" that invalidates Part 86-2 is so clear that a "finding" on that ground would not be speculation, but rather, confirmation of the obvious and the undisputed.

a. The individual rates. That the challenged rates are not related to reasonable costs is underscored by the following:

(i) The 1975 Medicaid reimbursement rates for residential health care facilities were promulgated under Public Health Law §2807(3), which required the Commissioner of Health to certify that such rates were "reasonably related to the costs of efficient production" of services rendered by each facility for which rates were certified.*

(ii) As of January 1, 1976, instead of promulgating new rates, as required by §2807(3), the Commissioner "froze" the 1975 rates for utilization in 1976, notwithstanding indisputable increases in the cost of delivering medical services.** Moreover, the rates which were announced on November 1, 1976 effected reductions for over 60% of the nonprofit residential health care facilities in the State, from the rates which had already been "frozen" at 1975 levels.

Catholic Medical Center, supra, is directly in point, since the "freeze" there held to be illegal was a freeze of rates certified under the same §2807(3) standard pursuant to which the 1975 Medicaid reimbursement rates had been certified for residen-

* Accordingly, in promulgating the 1975 rates, the Commissioner of Health certified that the costs upon which they were based were reasonably incurred and that there was no identifiable inefficiency in the rendition of the services which were being reimbursed.

** Had the federal standard of "reasonable cost-related basis" been in effect on January 1, 1976, there is no question that the "freeze" would have been illegal under that standard and the rationale of Catholic Medical Center, supra, and the cases which follow it.

tial health care facilities:

"[i]n fixing rates, the Commissioner was required from the outset to fix rates reasonably related to the costs of efficient production of such services.... The Commissioner of Health's determination of hospital reimbursement rates in 1968 therefore must have involved a finding that 'the rates were reasonable and were not inflated by inefficient operations or improper costs.'" (305 F. Supp. at 1265)

The Court in Catholic Medical Center ultimately concluded that the "freeze" of rates calculated under such a standard could not produce the "reasonable cost" reimbursement required by the statute involved. In the instant case, Part 86-2 did more than just "freeze" rates that had been calculated pursuant to Public Health Law §2807(3); it actually lowered 60% of them. That the cuts to 60% of the members of the class were not the result of corresponding reductions in costs was amply demonstrated by the testimony on behalf of the named plaintiffs, each of whose 1976 costs increased from 1975. While no named plaintiff was ever told it was operating inefficiently, each had its medicaid reimbursement rate reduced.* On this basis alone, the rates produced by Part 86-2 would be violative of 42 U.S.C. §1396a(a)(13)(E).

b. The defects of the ceilings.

The method by which Part 86-2 limits reimbursement is the use of "ceilings" -- which effectively ensure that some part

* Similar cutbacks were inflicted on the class, as shown, on a sample basis, with respect to 20 other class members. (JA 222-224. See original record for exhibits.)

of a facility's actual costs will be disallowed as being "above" the ceiling. An understanding of the ceilings of Part 86-2 -- both their computation and application -- demonstrates that even apart from their budgetary motivation they are so unrelated to actual cost that any reimbursement system based upon them could not produce rates on a "reasonable cost-related basis". Stated differently, if reimbursement is limited by extraneous factors demonstrated to have nothing whatever to do with cost, then the resulting rates cannot be cost related.

The factors which most distort the ceilings utilized in Part 86-2 are the failure to "group" facilities by geography and sponsorship for purposes of determining cost-experience, as had been required by Public Health Law §2807(3); basing reimbursement completely upon a "rating system" that is concededly unrelated to cost; and, utilizing a "percentile" limitation, which necessarily excludes costs regardless of their reasonableness.

(i) Failure to Group By Sponsorship and By Geography

As detailed above, reimbursement rates calculated under Part 86 were certified as being "reasonably related to the costs of efficient production." Facilities were grouped to establish cost patterns for comparable facilities, based upon the following factors: type of sponsorship of the facility (proprietary vs. nonprofit), its geographic location, and its size (the number of beds). After a facility was placed into a group (e.g., nonprofit facilities in the Rochester area with between 50 and 100 beds), an "average cost" of the group's facilities for particular services was determined. This average cost then served as the basis for setting a "ceiling" on reimbursement, under which reimbursement was disallowed for expenses

which exceeded the group's average by more than a given percentage. *

Part 86-2 eliminated geography and sponsorship as bases for grouping facilities.** Grouping by type of sponsorship had served to give recognition to differences in the "patient mix" of different facilities. Since, statistically, nonprofit facilities as a group have "sicker" patients than proprietary facilities,*** this factor prevented a facility with a more infirm population -- which, consequently, required more intensive nursing, medical and other services -- from having its necessarily incurred reasonable costs disallowed because its cost per patient was substantially higher than the per patient cost in a facility with a healthier, perhaps younger population, which had no need for the same intensity of care.

Similarly, use of geography in grouping facilities under Part 86 had prevented unfair comparisons. A facility located in New York City, with its attendant higher insurance, supply and other operating costs would obviously show a much greater per patient cost with respect to such items than would a facility located, for example, in a small town in northern or western New York State. Both could be rendering a comparable degree of patient

* Thus, if the average daily cost was \$50, and the ceiling was set at 115% of the average, then any facility in the group with costs in excess of \$57.50 (115% of \$50) would have the excess disallowed from its reimbursement rate.

** While ceilings under Part 86 were based upon a group average cost, Part 86-2 replaced the use of average cost with a percentile cost (i.e., the cost incurred by the facility at the 60th percentile). The arbitrary nature of this limitation is discussed below.

*** This was confirmed by the Department of Health's own finding (JA 184) that on the average, nonprofit facilities discharged fewer patients to hospitals than did proprietary facilities.

care and both could be equally efficient and prudent in incurring expenses, yet the facility located in the higher cost geographic location will compare unfavorably.

By using size as the only criterion for grouping, facilities caring for patients requiring more intensive care were subjected to unfair reimbursement limitations because their costs were necessarily higher than the costs incurred by facilities which, because their patients required less intensive care, were rendering an entirely different mix of services, or which were, for reasons wholly unrelated to efficiency or prudence, able to obtain goods and services at substantially lower cost.

In Rosado v. Wyman, 397 U.S. 397 (1970), New York attempted to justify, on the basis of "administrative efficiency", a changeover from a "computed grant maximum" to a "flat grant maximum" system which had the effect of reducing aggregate State payments required to be made under the welfare program in question. 397 U.S. at 417. Prior to New York's conversion, however, Congress enacted a statute requiring states to adjust grants to reflect changes in living costs. Accordingly, since the "flat grant" system admittedly excluded elements of need which were recognized in its former system, the changeover was invalidated.

In the instant case, there has been no showing that the "reasonable cost of efficient production" standard of Public Health Law §2807(3) was any different than the "reasonable cost-related" standard of 42 U.S.C. §1396a(a)(13)(E), nor has any justification been put forward by the State for changing the grouping under Part 86-2 which was designed to produce the rates required under Public Health

Law §2807(3). As in Rosado, the State should be required to maintain its plan so as to retain the methodology which has been found to comply with federal standards.

(ii) The Rating System is Unrelated to Costs

As discussed above, the rating system was conceived as no more than a means of advising patients of the quality of care in particular facilities. Indeed, the fact that the rating system was unrelated to the costs involved in delivering the rated services has been openly acknowledged by representatives of the Department of Health. (JA 79)

Thus, if a facility received a "Good-State" rating based upon the survey of a particular service, that facility is limited in its reimbursement by the amount spent by the facility at the 60th percentile of all facilities with this same rating. This would be true even though there is no demonstration that the facility's bona fide costs are any less than the costs incurred by a facility which secured the higher "Very Good" rating, which would not be limited by any ceiling. Furthermore, a facility receiving the "Good-Federal" rating, thereby demonstrating its compliance with every single certification requirement necessary for participation in Medicaid, would be limited in its reimbursement to the amount spent by a facility at the 35th percentile of all facilities receiving the "Good-State" rating.

Moreover, the record is barren as to the relationship between the various ratings. In other words, how was it determined that the 35th percentile limitation somehow reflected the difference

between the costs incurred in securing a "Good-State" and a "Good-Federal" rating? These questions are unanswered because, in the development of the rating system, the State never asked the questions.

Finally, even if the rating system had been developed to measure costs, so that there could be reasonable ceiling limitations based upon such a rating system, in the instant case the uncontradicted fact is that whatever rating system was to be "developed" could not have been ready to be applied to residential health care facilities for at least a full year after the enactment of Chapter 76.*

In any event, the rating system remained a component of the reimbursement methodology in the legislation which was signed into law, and within six weeks of the legislation every facility had miraculously received a "rating" for reimbursement purposes. The ratings used were based in many cases on "stale" surveys; and such surveys, when conducted, had not been related to any of the criteria of the rating system ultimately employed.

Accordingly, even if the reimbursement methodology of Part 86-2 were not invalid for each of the independent reasons previously discussed, the fact that it was based on a rating system unrelated to costs and implemented in the fashion described above, would require its invalidation as not being calculated to produce rates on a reasonable cost related basis. (JA 20)

- (iii) Limitation by "Percentile" Necessarily Excludes Reimbursement for Expenses Without any Determination that They are Unreasonable

* The Commissioners of Health and Social Services advised the Governor, in March, 1976, that such a rating system could not be effectively implemented for at least one year. (JA 90) Thus, they specifically proposed that the Governor eliminate from Chapter 76 the requirement that reimbursement be tied to a rating system. Absent this, the Commissioners acknowledged that the "spirit" of the legislation might be followed, but not its letter. (JA 91)

Even if plaintiffs did not object to the groupings of Part 86-2 (if, for example, the old Part 86 groupings for purposes of determining ceilings remained in effect) one further factor would render the reimbursement methodology invalid under 42 U.S.C. §1396a(a)(13)(E) -- the utilization of a "percentile" to develop a ceiling limitation.

This limitation operates as follows: If the 60th percentile is used as the basis for excluding costs for homes with a rating of "Good-State", and there are 100 facilities in the group, the 40 facilities with the highest costs would have some portion of those costs excluded from their reimbursement -- regardless of whether their costs could be demonstrated in their entirety to be prudent, efficient or reasonable. Thus, if every facility in the group had costs within \$2.00 of the other (as, for example, a range between \$53 per patient day and \$55 per patient day), if the facility at the 60th percentile had a cost of \$54.25, every one of the 40 facilities between \$54.25 and \$55 would have some portion of its actual costs excluded. Under the former methodology of Part 86, which utilized "averages", every one of the 100 homes would have had its costs reimbursed, since they would all fall within 115% of the average. A ceiling limitation which automatically excludes portions of costs cannot possibly produce reimbursement on a "reasonable cost-related basis".

Defendants' Purported "Prudent Buyer" Defense

In the absence of probative evidence to contradict that offered by plaintiffs, defendants resorted to the argument that the new reimbursement methodology of Part 86-2, and the resulting sharp reimbursement reductions, reflected the operation of the

"prudent buyer" concept added to the Public Health Law by the Legislature in the 1975 amendments to Public Health Law §2808.* In the face of the legislative and executive history of Part 86-2, we believe the argument to be disingenuous.

In the first instance, there was no evidence adduced to show that there was any difference whatever between the "prudent buyer" concept embodied in Public Health Law §2808(1)(a), and the §2807(3) standard, which limited reimbursement to costs that were "reasonable" and "efficient". The latter standard formed the basis for computing the 1975 rates, precipitously reduced under Part 86-2. In fact, defendants' main witness, Dr. Cicero, acknowledged that the reimbursement provisions of Public Health Law §2807(3) and the "prudent buyer" concept were "very similar". (JA 1385, 1386)

Defendants will undoubtedly point to the percentile limitations placed as ceilings upon reimbursement rates, as implementing the so-called "prudent buyer" concept. This claim would have to be based on an assumption that any facility spending in excess of the ceiling was "imprudent". However, defendants' own witness acknowledged that the percentile levels were chosen because "health care was costing too much." (JA 765) There was no testimony that any study of facilities had been done.

Identical arguments by the State of New York were rejected in Catholic Medical Center, supra, in language particularly relevant to the facts at hand (305 F. Supp. at 1262):

"Apart from general assertions that hospitals could operate more efficiently, there was no

* Defendants, however, have made no attempt to demonstrate just how the alleged connection was made between that concept and the new rates.

evidence submitted to the court that any hospital costs were 'in excess of reasonable charges consistent with efficiency, economy, and quality of care' as provided in 42 U.S.C. §1396a(a)(30). The state in its investigation of individual hospitals seems to have limited itself to desk audits, which constitute merely study of figures submitted by the hospitals on uniform state report forms. No field audit has been held of any hospital." (305 F. Supp. at 1262)

Finally, an understanding of the statutory derivation of the "prudent buyer" concept totally belies the argument that facilities suffering rate reductions on November 1 were simply the victims of their own "imprudence". When the Legislature adopted the relevant provision in 1975, it directed the Commissioner of Health to promulgate regulations:

"consistent with regulations promulgated under the [Medicare Act], by which payment for costs incurred by a residential health care facility for a quantity and quality of supplies or services necessary for the proper operation of a residential health care facility shall not exceed those which would be paid in the normal course of business by a prudent buyer of such supplies or services." (Public Health Law §2808(1)(a)) (Emphasis added.)

The fact is, however, that each of the named plaintiffs had been subject to the very Medicare "prudent buyer" regulations referred to, which the Commissioner was now, on a State level, being directed to promulgate. Under 20 C.F.R. §405.451, a provider of services under Medicare is required to take advantage of discounts, bulk buying and other group practices which will insure lower costs. If a provider fails to take advantage of these practices, the amount of his allowable costs may be reduced accordingly. Each of the named plaintiffs testified that its Medicare reimbursement rate -- paid by the federal government for the same services rendered to Medicaid patients --

approximately equalled its 1976 actual costs per patient day.*

Unfortunately, the only time that defendants focused on the actual costs of plaintiffs was after this action commenced, when Dr. Cicero announced in court six weeks after the new rates went into effect that in response to this lawsuit his staff had prepared analyses to demonstrate what the five named plaintiffs could do to live within their new reduced rates. In the case of St. Cabrini, the suggestion was that the facility immediately fire 80 percent of its registered nurses and replace them with practical nurses and aides. (JA 1566-1567) Dr. Cicero admitted that prior to his reading the "analyses" in court, the plaintiffs had never been told that they were operating in any way which was "imprudent", "inefficient" or "unreasonable". (JA 1327) Indeed, as was admitted ultimately by Mr. Davidoff of the Department of Health, Dr. Cicero's analysis and subsequent "management assessment review" consisted of no more than ascertaining the dollar loss under the new rates and simply allocating it to services to be cut (JA 1951-1952); there were no independent reviews of the services or costs of the affected facilities. This "analysis" might almost have been humorous had the Department of Health not been tinkering with the well-being of thousands of the elderly ill of New York.

* For example, St. Cabrini's 1976 Medicare rate was \$69.64 per patient day, as compared with its actual costs of \$69.33; its November 1 Medicaid rate was \$55.00. (JA 753-754, 729, 740) Plaintiff Loretto had actual costs and a Medicare rate for 1976 of \$52.78 per patient day for its skilled nursing facility; its November 1 rate was \$42.30. (JA 835, 845, 836) Plaintiff Mohawk Valley had 1976 actual costs of \$55.44 per patient day and a Medicare rate of \$55.00 per patient day; its November 1 rate was \$28.96. (JA 861, 867, 863) Plaintiff Margaret Tietz had actual 1976 costs of \$72.67 and a Medicare rate of \$71.35; its November 1 rate was \$51.38 per patient day. (JA 897, 900, 899)

POINT II

THE FAILURE OF DEFENDANTS TO COMPLY WITH STATE AND FEDERAL PROCEDURAL REQUIREMENTS COMPELS INVALIDATION OF PART 86-2 AND THE RATES CALCULATED THEREUNDER

The discussion in Point I above of Part 86-2 and the rates calculated thereunder demonstrates, we submit, their substantive illegality on several independent grounds. However, the Court need not even reach the substantive illegality of the regulations and rates because the failure of defendants to comply with mandated State and federal procedures in promulgating them requires their invalidation.

A. Failure To Submit The Proposed Regulations To The New York State Medical Care Advisory Committee

The federal Medicaid Act requires that each State Plan provide for the establishment of a mechanism for "the review by appropriate professional health personnel of the appropriateness and quality of care and services...to provide guidance with respect thereto in the administration of the plan to the State agency." (42 U.S.C. §1396a(a)(33)(A)). To fulfill this statutory mandate, federal regulations require that each State Plan must provide for a "medical care advisory committee" which "will have adequate opportunity for meaningful participation in policy development and program administration...." (45 C.F.R. §246.10(a)(3)) (Emphasis supplied)

To comply with these federal requirements, the New York State Legislature enacted Social Services Law §365-c, which established a Medical Advisory Committee to "advise the Commissioner [of Health] with respect to health and medical

care services provided [under certain programs] including Medicaid." The committee was to be comprised of physicians and other health care professionals, and recipients and consumers of medical assistance for needy persons. It was required to meet at least once a year.

The importance of affording the Medical Care Advisory Committee an opportunity to consider proposed changes such as those embodied in Part 86-2 has been widely recognized. The federal Medical Services Administration's Medical Assistance Manual, CCH Medicare and Medicaid Guide ¶15,755 [hereinafter "Medicare Guide"] states, at 6751:

"A Medical Care Advisory Committee improves and maintains the quality of a medical assistance program by:

1. Contributing specialized knowledge and experience to be added to that available within the single State agency administering the program, and
2. Providing a two-way channel of communication with the individuals, organizations, and institutions in the community that, with the administering agency, provide and/or pay for medical care and services.

* * *

These broad perspectives and specialized knowledge are needed to plan the medical assistance program, to formulate the policies that guide it, to set standards, and to evaluate and interpret the problems and needs of the professional groups to the public and vice versa."

When the State of Connecticut, because of budgetary considerations, attempted to impose a ten percent reduction in fees paid to providers of medical services and supplies under the Connecticut Medicaid program, and to cut back on reimburse-

ment for certain types of service, the court preliminarily enjoined the cutbacks on the grounds that the Department of Social Services had not complied with federal prior notice requirements, and had failed to consult with the State's Medical Care Advisory Committee. Robinson v. Maher, Medicare Guide ¶27,707 (D. Conn. 1976). The court focused on the important purpose served by the Committee:

"It may well be that such a consultation with practicing physicians, other health care professionals, and representatives of groups of health service consumers who are on that committee, . . . might suggest to the commissioner alternative ways to reduce expenditures, in a manner which would not diminish the availability or the quality of health services for the needy, thus avoiding unnecessary hardship." (Id. at 9053)

The court concluded that to reduce or terminate benefits "without the required input of medical professionals and others which might have affected the extent, the categories and the nature of the cutbacks" (Id. at 9053), constituted irreparable injury to the plaintiff class, and demonstrated plaintiff's strong likelihood of success on the merits.*

Similarly, in Benton v. Rhodes, Medicare Guide ¶28,025 (S.D. Ohio 1976) the Ohio Department of Public Welfare was preliminarily enjoined from implementing any reduction in benefits under the Medicaid program until the Medical Care Advisory Committee was afforded an "adequate opportunity for meaningful participation in the reduction decision" (Id. at 10,144)

* The failure of state agencies to afford a federally mandated consultative body the opportunity to participate in formulation of a particular policy has in other contexts been held to require invalidation of the policy. See Chacon v. Hodgson, 465 F.2d 307 (7th Cir. 1972); Lower East Side Neighborhood Health Council-South, Inc. v. Richardson, 346 F. Supp. 386 (S.D.N.Y. 1972); Comprehensive Group Health Services Board of Directors v. Temple University, 363 F. Supp. 1069, 1098-1110 (E.D. Pa. 1973).

In the instant case, defendants have conceded that New York's Medical Care Advisory Committee has not met within the past year, as required by Social Services Law §365-c(3), and that it "was not consulted about the adoption or implementation of Parts 88 or 86-2 or the rates calculated thereunder" (JA 230). As the authorities cited above establish, this admitted flouting of a federal requirement embodied in both statute and regulation requires the invalidation of Part 86-2 and the rates calculated thereunder.

B. Failure to Give Timely and Adequate Notice To Medicaid Recipients Of A Proposed Reduction Of Benefits

The reductions in assistance to Medicaid recipients which were effected by the November 1, 1976 rate reductions triggered the prior notice provisions of 45 C.F.R. §205.10(a)(4)(i) and (a)(4)(iii). These regulations require that "timely" and "adequate" notice be given of intended action to discontinue, suspend or reduce assistance.* Here, no prior notice of any kind was given, and this violation of the applicable federal regulations voids the State's action.

* "Timely" notice is defined (with certain exceptions not applicable here) as notice mailed "at least 10 days before. . . the date upon which the action would become effective." (45 C.F.R. §205.10(a)(4)(i)(A)) "Adequate" notice means:

"a written notice that includes a statement of what action the agency intends to take, the reasons for the intended agency action, the specific regulations supporting such action, explanation of the individual's right to request an evidentiary hearing (if provided) and a State agency hearing, and the circumstances under which assistance is continued if a hearing is requested...." (45 C.F.R. §205.10(a)(4)(i)(B))

(Footnote continued on next page.)

In Robinson v. Maher, supra, it was conceded that notice of Medicaid cutbacks had been sent to recipients less than ten days prior to the intended effective date of the cutbacks. The court cited this concession (together with Connecticut's failure to consult with its Medical Care Advisory Committee) as demonstrating "a very substantial probability that the plaintiffs would succeed at trial . . .", warranting the issuance of a preliminary injunction.

In Rochester v. Baganz, 479 F.2d 603 (3d Cir. 1973), failure to comply with the federal prior notice regulations compelled reversal of summary judgment in favor of the State of Delaware, where the State attempted to impose an 11.7% reduction in welfare benefits. The Third Circuit echoed the argument of the third party defendant Secretary of Health, Education and Welfare, that:

"in a program designed to meet subsistence needs recipients ought to be informed in advance if their payments are to be cut for any reason, so that they may be able to plan for the cut, and to the extent possible adjust to it." (479 F.2d at 606)

In Benton v. Rhodes, supra, although timely notice of Medicaid cutbacks was given, the court found the notice to be

(Footnote continued from previous page)

Where the action is taken by the agency on a class-wide basis, because it is compelled by changes in state or federal law, notice is deemed "adequate" if it:

"includes a statement of the intended action, the reasons for such intended action, a statement of the specific change in law requiring such action and a statement of the circumstances under which a hearing may be obtained and assistance continued."
(45 C.F.R. §205.10(a)(4)(iii))

inadequate within the meaning of the federal regulations and issued a preliminary injunction preventing implementation of the cutbacks until notice complying with the regulations was given to all affected recipients. See also Brown v. Wohlgemuth, 371 F. Supp. 1035 (W.D. Pa.), aff'd, 492 F.2d 1238 (3d Cir. 1974).

C. Failure to Provide an Opportunity For Hearings
Prior to Reducing Medicaid Benefits to Recipients

To ensure that individuals are not deprived of their very means of survival without a prior opportunity to challenge the basis of administrative action which would result in such deprivation, the federal regulations implementing the Medicaid Act expressly provide for prior hearings.*

Pursuant to 45 C.F.R. §205.10(a)(5), any applicant whose financial or medical assistance is denied, or not acted upon sufficiently promptly, and any recipient "who is aggrieved by any agency action resulting in suspension, reduction, discontin-

* Although embodied in regulations, the entitlement to such a hearing is constitutional in dimension. See Goldberg v. Kelly, 397 U.S. 254 (1970); Memorial Hospital v. Maricopa County, 415 U.S. 250, 259-60 (1973); Benton v. Rhodes, supra. In a subsequent memorandum and order denying a motion to vacate or to stay pending appeal the preliminary injunction previously entered, the Benton court declared:

"Like Goldberg, these cases concern not only the quality of life, but life itself The provision of such medical assistance is in my judgment no less important to a person for whom it is medically indicated than is the receipt of Aid to Families with Dependent Children by persons such as the plaintiffs in Goldberg. Here, as in Goldberg, 397 U.S. 254, 264 (1970); "[T]ermination of aid pending resolution of a controversy over eligibility may deprive an eligible recipient of the very means by which to live while he waits."

uance or termination of assistance" is entitled to a hearing. Where, however, state or federal law requires benefit "adjustments for classes of recipients" a hearing is required only to correct errors in the computation of benefits payable. If a recipient requests a hearing, the request has the effect of barring the agency from suspending, reducing or terminating benefits until the decision is entered after the hearing. (45 C.F.R. §205.10(a)(6)(i))

These provisions, coupled with the notice provisions discussed above, insure that in every case where intended agency action will adversely affect the right of a recipient to continue to receive his present level of benefits, he is entitled to be apprised of the intended action and to be heard as to the effect of the government policy on him, the wisdom of the policy, and any computational or interpretive errors* in applying the policy to him, before he suffers its impact.**

Thus in Virginia Hospital Ass'n v. Kenley, Civil Action No. 76-0300-R (E.D. Va., December 3, 1976) (Plaintiffs' Addendum,

* Even where not expressly provided by statute or regulation, due process requires that, in the context of welfare benefits, such as in Goldberg, and Medicaid benefits, as in Benton, the opportunity be afforded to show that an across-the-board reduction does not apply to a particular benefit claimant. See Yee-Litt v. Richardson, 353 F. Supp. 996 (N.D. Cal.) (three-judge court), aff'd without op., 412 U.S. 924 (1973); Mothers' and Children's Rights v. Sterrett, 467 F.2d 797, 800 (7th Cir. 1972); Russo v. Kirby, 453 F.2d 548, 551 (2d Cir. 1971); cf. Almenares v. Wyman, 453 F.2d 1075, 1079 n.3 (2d Cir. 1971), cert. denied, 405 U.S. 944 (1972).

** If, in the course of the hearing, a determination is made that the sole issue raised is "one of State or Federal law or policy, or change in State or Federal law and not one of incorrect grant computation" benefits may then be suspended, reduced, discontinued or terminated.

Doc. No. 12), the court preliminarily enjoined implementation of an amendment to Virginia's State Plan which would have limited reimbursement for in-patient hospitalization care to 21 days. The court cited the failure to provide timely or adequate notice, and the right to a hearing under 45 C.F.R. §205.10, as demonstrating that the plaintiffs "would more probably succeed at trial." (Id. at 14)

The failure of the defendants here to afford notice or an opportunity for a hearing to the Medicaid recipients suffering benefit reductions effectively precluded them from making known to the State their comments, criticisms and suggestions with respect to the challenged regulations and rates before they went into effect. As a result, this Court should -- as a matter of federal and state law -- hold that the reductions effected by the November 1, 1976 rates are illegal.

D. Failure To Comply With New York State Statutory Requirements

Defendants have also disregarded three New York statutory provisions requiring specific action by the State before the challenged regulations could take effect: N.Y. Exec. L. §101-a(2), N.Y. State Ad. Proc. Act §202(2), and N.Y. Public Health L. §2807(4).

N. Y. Executive Law §101-a requires, among other things, that at least 21 days prior to the adoption of any rule*, detailed

* "Rule" is defined as:

"the whole or part of each agency statement of general applicability or regulation or code that implements or applies law, or prescribes the procedure or practice requirements of any agency, including the amendment, suspension or repeal thereof. . ." (N.Y. Exec. Law §101-a(1)(b))

notice* be given to both the temporary president of the Senate and the speaker of the Assembly. Defendants have made no showing that the required notice has been provided. This failure to comply with the legislative pre-notification provision requires the voiding of administrative action taken pursuant to the rule. See Sturman v. Ingraham, 52 App. Div. 2d 882 (2d Dep't 1976); cf. People v. Cull, 10 N.Y. 2d 123 (1961).

Similarly, defendants concede their failure to comply with the provisions for notice and comment required by N.Y. Administrative Procedure Act §202(2), but rely on an exception, §202(2)(c), which permits an agency to dispense with the requirements of prior notice and opportunity to present views, upon a finding that the rule must be adopted as an "emergency" measure.

The "reason" offered here in support of the "emergency" finding appended to Part 88, was the existence of a fiscal crisis. However, as made clear by the holdings of such cases as Flushing National Bank v. Municipal Assistance Corp., 40 N.Y. 2d 731 (1976) and Catholic Medical Center of Brooklyn and Queens v. Rockefeller, 420 F.2d 1297 (2d Cir.), appeal dismissed, 400 U.S. 931 (1970), State budgetary difficulties do not provide the basis for riding roughshod over clear rights.**

* The required "notice" must include the text of the proposed rule, the statutory authority for its promulgation, the manner in which "data, views or arguments" concerning the proposed action may be submitted and an assessment of fiscal consequences on state and local government.

** A similar failure to conduct public hearings and to undertake "meaningful consultation" with a consultative body, as required by California law, resulted in the invalidation of certain regulations embodying Medicaid cutbacks, notwithstanding the certification by the State agency that a "fiscal emergency" existed. See California Medical Association v. Brian, Medicare Guide ¶26,631, 30 Cal. App. 3d 637 (Ct. of App. 1973).

Finally, under §2807(4) of the Public Health Law, Medicaid reimbursement rates may not become effective until 60 days after the the Commissioner of Health notifies each residential health care facility of its approved reimbursement rate. Notice of the 1976 rates for residential health care facilities was given on November 1, 1976. Contrary to the Public Health Law, the rates purported to go into effect immediately with retrcactive effect to January 1, 1976.

In a case precisely on point, a New York court construed Public Health Law §2807(4) to bar an attempt by the State to apply a reimbursement rate until 60 days after notice had been properly given. Hurlbut v. Whalen, ___ Misc. 2d___, 387 N.Y.S.2d 509 (Sup. Ct., Monroe Co. 1976). In the instant case, it is not controverted that 60 day prior notice was not given to the plaintiff class, and the holding in Hurlbut is, therefore, dispositive as to the procedural invalidity of the challenged regulations and rates.

POINT III

DENIAL OF APPELLANTS' MOTION FOR A PRELIMINARY INJUNCTION CONSTITUTED AN ABUSE OF DISCRETION

A. The Applicable Legal Standard for Injunctive Relief

This Court has made clear that an alternative standard is applied to determine whether a preliminary injunction should be granted. The party seeking the writ must demonstrate either the probability of success on the merits and "possible irreparable injury", or that there are "serious questions going to the merits to make them a fair ground for litigation" together with a "balance of hardships tipping decidedly" in his favor. Sonesta

International Hotels Corp. v. Wellington Associates, 483 F.2d 247, 250 (2d Cir. 1975). Under either of these formulations, relief should have been granted in the instant case.

1. Irreparable Harm

The one element common to both of the Sonesta tests is the necessity of some showing of possible irreparable harm. Jacobson & Co. v. Armstrong Cork Co., ___ F.2d ___, (Docket No. 76-7336) (2d Cir., Jan. 25, 1977) (slip op. at 1549-40 n.3); Triebwasser & Katz v. American Telephone & Telegraph Co., 535 F.2d 1356, 1359 (2d Cir. 1976). The record demonstrates that here it is a certainty, not a mere possibility.

The consequences of the Medicaid cutbacks challenged in this proceeding were starkly portrayed in testimony. The effect on patients of curtailing nursing care, eliminating recreational, rehabilitative, and other programs, the elimination of orderlies and other staff personnel, and the other "economizing" measures forced upon the plaintiff class are set forth in the affidavits and testimony of more than 10 health care professionals and two patients. *

The medical director of Beth Abraham Hospital, one of the members of the plaintiff class, left no doubt as to his conclusions regarding the cutback:

"Any further staff reductions would result in a disaster. The health of every patient would be threatened. Inevitably the death of many would result." (JA 613).

* (See, e.g., JA 239-241, 253-405, 613-620, 629-656, 901-902)

(See also JA 391, 902) The record is barren of evidence to contradict the testimony that patients confined in nursing homes that were or may be forced to make substantial and precipitate reductions in medical assistance are confronted with the imminent possibility of physical deterioration, injury or death.

Furthermore, the evidence presented below indicates that, because of the precarious financial conditions of many class members, the imposition of Medicaid reimbursement rates lower than the "frozen" 1975 rates which they had received up until November 1, 1976, threatens their ability to survive. (See, e.g., JA 49-73) The loss to the community of a residential health care facility providing essential patient care is a loss which cannot be equated with dollar damages, nor can it be remedied by the ultimate injunctive relief sought in this action. Moreover, the record makes clear that the capacity to absorb patients displaced by the closing of a residential health care facility may not be available in neighboring facilities, creating cruel problems for the patients. (JA 52, 66) Coupled with the serious physical consequences of dislocating aged and infirm patients, this too constitutes irreparable harm.

2. Likelihood of Success

The various procedural, statutory and constitutional violations described in Point II, supra, make clear the likelihood that appellants will prevail on one or more of these issues.

The failure of the State to consult with its Medical Care Advisory Committee has been cited by two courts as a sufficient ground for reaching such a conclusion.* The failure to comply with federal regulations which require adequate and timely notice of benefit reductions has brought at least four courts to a similar conclusion.**

The constitutional and statutory violations involved in the State's failure to give benefit recipients a hearing prior to reducing benefits would support judgment for appellants.***

The failure of the State to satisfy the various New York statutory procedural requirements in promulgating its regulations provides still further support for the conclusion that appellants will prevail on the merits.****

With respect to the merits of the principal underlying issue -- the compliance of the State Medicaid regulations with Federal law -- there is no denying that Social Security Act litigation is among the most complex; but nursing homes are entitled to be reimbursed on a reasonable cost related basis, and if the evidence adduced is not yet sufficient for judgment, it is, at the

* Robinson v. Maher, supra, at 9052-53; Benton v. Rhodes, supra, (opinion of May 11, 1976) at 8.

** Rochester v. Baganz, supra; Robinson v. Maher, supra; Brown v. Wohlgemuth, supra; Virginia Hospital Ass'n v. Kenley, supra, at 8-11.

*** See Virginia Hospital Ass'n v. Kenley, supra.

**** See Point 1(D) supra.

very least, sufficient to establish the issue as "a fair ground for litigation."*

3. The Balance of Hardships

The fundamental purpose of granting preliminary injunctive relief is to preserve the status quo of the parties pending the determination of the dispute.**

If appellants' motion for a preliminary injunction is granted, defendants will be required, during the pendency of this lawsuit, to continue to pay Medicaid reimbursement at the pre-November 1 rates to all facilities that suffered reductions below such rates as a result of the application of Part 86-2. Those rates clearly represent the "status quo", since as of November 1, they had been in effect for 22 months. Moreover, should the State prevail after trial, it can be restored to the position it was in prior to entry of an injunction by allowing it to recoup the "overpayments" from monies which will then be payable to, or will in the future become payable to the members of the plaintiff class covered by the injunction. See Virginia Hospital Ass'n, supra, at 14.

* See New York Pathological and X-Ray Laboratories, Inc. v. Immigration and Naturalization Service, 523 F.2d 79, 80 (2d Cir. 1975); Jacobson & Co., Inc. v. Armstrong Cork Co., supra (slip op. at 1548).

** Unicon Management Corp. v. Koppers Co., Inc., 366 F.2d 199, 204 (2d Cir. 1966); Hamilton Watch Co. v. Benrus Watch Co., 206 F.2d 738, 742 (2d Cir. 1952).

On the other hand, since defendants have maintained that the federal courts are powerless under the Eleventh Amendment to order the state to make retroactive payments to plaintiffs or members of the class, if they are not enjoined from making further payments under the challenged rates, there is a danger that plaintiffs and members of the class will be without a remedy in the federal courts to recover the amounts that should have been paid if they ultimately succeed on the merits. See Virginia Medical Ass'n v. Kenley, supra, at 13-14.

If the injunction is not granted, and appellants prevail in this action, no amount of money will restore human life, nor adequately compensate for the pain, anguish and indignity suffered as a result of medical care cutbacks or the closing of residential health care facilities for lack of funds.*

B. The Applicable Legal Standard for Appellate Relief

Plaintiffs are well aware of the strict test applied by this Court in reviewing orders granting or denying preliminary injunctions:

"[I]ssuance of a preliminary injunction . . . is in the district court's discretion and will not be overturned absent a showing of abuse or mistake." (Jacobson & Co., Inc. v. Armstrong Cork Co., supra (slip op. at 1549))

However, this Court has not hesitated, where appropriate,

* See Ryan v. Shea, 394 F. Supp. 894, 901 (D. Colo. 1974), aff'd, 525 F.2d 268 (10th Cir. 1975); Robinson v. Maher, supra.

to intercede to correct district court mistakes or abuses of discretion, both in issuing (Triebwasser, supra), and in denying preliminary injunctions (New York Pathological and X-Ray Laboratories Inc., supra; Sonesta International Hotels Corp., supra; Dino DeLaurentis Cinematografica, S.p.A. v. D-150, Inc., 366 F.2d 373 (2d Cir. 1966)).

A review of the entire record in this case leads inescapably to the conclusion that denial of the preliminary injunction by the district court was a clear abuse of discretion, calling for the intercession of this Court to direct the granting of the injunction sought below.

CONCLUSION

For the foregoing reasons, plaintiffs request that the order of the district court denying the motion for a preliminary injunction be vacated and that this Court direct the entry of an order enjoining defendants, pending determination of this action on the merits, from applying Part 86-2 of 10 N.Y.C.R.R., or the Medicaid reimbursement rates promulgated thereunder, to the class of nonprofit residential health care facilities on whose behalf this action is brought, insofar as such Medicaid reimbursement rates effect reductions in the rates at which said facilities were being reimbursed as of October 31, 1976.

Plaintiffs further request that, because of the demonstrated irreparable injury, the relief herein prayed for be granted pending determination of the appeal.

Dated: New York, New York
March 29, 1977

Respectfully submitted,

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